SOCIAL SECURITY--DISABILITITY DETERMINATION SERVICES

PHYSICAL DISABILITY EVALUATION GUIDELINES

Chief Complaint

State the major or chief complaint(s) alleged as reason for inability to work. Describe how the impairment(s) affect function and daily activities. Be specific and provide examples.

History

1. **Brief summary or list of background material/medical records reviewed**
2. History of present illness
    A. Date of onset of illness or impairment.
    B. Progression of symptoms.
    C. Treatment and response.
    D. Current medications.
    E. Factors that increase the problem.
    F. Factors that provide relief.
    G. Brief description of activities of daily living.
2. Past history.
    Describe other prior illnesses, injuries, operations, or hospitalizations. Give dates of these events.
3. Social history.
    Include pertinent findings about use of tobacco products, alcohol, non-prescription drugs, etc.
4. Family history (if pertinent).
5. Include brief statement regarding background materials received for reviewed prior to evaluation.

Review of Systems

Review all body systems. Describe any specific complaints.

Physical Examination

1. Vital signs:
    A. Blood pressure;
    B. Pulse rate;
    C. Respiratory rate;
    D. Height and weight without shoes.
2. General appearance.
    Describe the claimant's general appearance and pertinent actions during the examination.
    For example, if the person has back problems, describe how the person stood, arose from the chair, got on and off the examining table, etc.

3. Specific findings.
   The examination should concentrate on the systems affected by the claimant's illness or impairment. ***Be as detailed as possible****.*

   A. Cardiac: Rate, rhythm and sounds, including any murmurs. Evidence of vascular congestion. Description of chest pain.
   B. Pulmonary: Describe breath sounds, dullness, wheezes, rales, or coughs.
   C. Musculoskeletal: Provide range of motion in degrees (for example, "flexion in L-spine to 60 degrees.") Gait and station. SLR. Ability to use hands to grasp, grip, and manipulate objects. Describe any muscle spasm, atrophy, or joint deformity.
   D. Neurological: Describe motor function (0 to 5 scale, 5 is normal), reflex activity, and any sensory deficits (for example, "the claimant had diminished pin prick over the left calf.")
   E. *****DO NOT PERFORM PELVIC or BREAST EXAMINATIONS UNLESS AUTHORIZED*****

Laboratory and Diagnostic Studies

Do not perform studies unless they have been specifically authorized in advance.

Lab tests: Report actual lab values, with the lab's normal range, or attach the laboratory report sheet to the signed report.

Diagnosis and Prognosis

1. Provide diagnosis and prognosis based on clinical, objective evidence.
2. Explain which findings led to the given diagnosis.
3. Do not give diagnoses based solely on the claimant's subjective complaints.

Medical Source Statement (remaining functional abilities)

Based on the objective examination findings, give an opinion of the claimant's ability to perform work related physical activities such as standing and walking, lifting and carrying, sitting, fingering, etc. State, which findings led to the assessment.